APPENDIX C:

2255 Hearing Testimony Transcripts

differences are in psychiatric patients.

So the sample here are not healthy adults but rather people with major mental illnesses that require inpatient hospitalization, again, like bipolar disorder or schizophrenia.

This study shows what I said was true about healthy people as well, that differences of the magnitude we see in Ms. Montgomery are quite rare even in individuals with major mental illness.

Q Is this article an article that you were looking at at the time that you had been retained by the trial team in Mrs. Montgomery's case?

A Yes.

Q In fact, does it show where you have actually made some underlines and circles around different charts and things? An example here.

A Yes. So this is my handwriting, my circles that I would have made around the time shortly -- while I was analyzing the data shortly after I saw Ms. Montgomery in July of 2007, and this is a table, this is Table 1, shows how common, again, it is to see differences like Ms. Montgomery shows. For example, she showed a 29-point difference. That's seen in less than -- a difference that size favoring nonverbal I.Q. is seen in less than 1 percent of the psychiatric inpatient population.

Q So I want to ask you now, if you could, for purposes of

the record, explain the difference between verbal I.Q. and performance I.Q. and why that's significant? What's the verbal test and what is the performance test?

A Well, intelligence is a broad multifactorial construct. It involves intelligent behavior. It involves verbal skills, like being able to read verbally and express oneself with a good vocabulary, and it involves nonverbal or visual intellectual abilities, like spacial navigation or visual attention to detail, and so the most widely used intelligence test in the United States measure both nonverbal intellectual abilities and verbal intellectual abilities. Most tests, including the one that Ms. Montgomery was given, those are summed and then comprised an overall I.Q. score.

We also know that the two hemispheres of the brain are specialized for different kinds of intelligence. So in most people the left hemisphere or verbal side of the brain subserves and supports verbal I.Q.; and, conversely, the right hemisphere in most individuals subserves the performance I.Q. or the nonverbal intellectual abilities.

Q So is it fair -- and I could be summarizing this wrong so correct me if I'm wrong. Is it fair to say that when you have someone such as Mrs. Montgomery with this extremely rare split between verbal I.Q. and performance I.Q., that could be an indicator that there is something cognitively wrong, some brain damage in one side of the brain versus the other?

A Correct.

MS. HENRY: Your Honor, I would like to, with your permission, mark the article that Dr. Fucetola's been referencing as Movant's Exhibit 143 and ask it be accepted into evidence.

MR. VALENTI: No objection.

THE COURT: Received.

Q (By Ms. Henry) In addition to the I.Q. testing that you performed on Mrs. Montgomery, did she also have a -- let me back up.

I'm going to move on. That's where I'm going. Did you see a potential source of cognitive dysfunction with Mrs. Montgomery as a result of her performance on the Faces Test?

A Yes. What alerted me actually to the highly unusual finding was a stark difference between her visual memory abilities and her nonverbal I.Q. Again, the base rate of the size of the difference that she showed in that, which was in the 30- to 40-point range, was highly unusual. The fact that her visual memory score was so much lower than you would expect given her performance I.Q. was a function of poor per -- relatively poor performance on a facial memory test in which Ms. Montgomery had to learn and then reliably remember a set of new faces of people she had never seen before.

Q So I want to show you what I will mark as Movant's Exhibit 144. Is that a chart that was in your file that

to Mrs. Montgomery at the conclusion of your evaluation now being 2007?

A Yes. I gave several diagnoses.

Q What were those diagnoses?

A Well, one was posttraumatic stress disorder, chronic, that began back in her adolescence with sexual abuse and physical abuse by her stepfather. I think what now carries the name in some circles of complex PTSD.

The second one was major depressive disorder, recurrent. I noted it was without psychotic features at that time but without full interepisode recovery. In other words, she always remained somewhat depressed and there wasn't a complete recovery from the major depression that I had seen before. And I did mention that at times it had included psychotic features like hallucinations.

And then I also got -- noted a rule-out diagnosis, which is a term of art. It actually means to continue to consider it but not eliminate it yet, a bipolar disorder.

And then finally a somatoform disorder, not otherwise specified, which I labeled pseudocyesis. It's rare enough that it's not -- doesn't really have a category in the DSM all by itself.

Q And what is a somatoform disorder?

A A somatoform disorder is where somebody develops an idea that they are ill from some condition or a distortion of

Q And you worked with the Veterans Administration for how long?
A Six years.
Q Immediately prior to your employment with the Veterans Administration did you work for the Federal Bureau of Prisons?
A I worked at the Federal Bureau of Prisons at FMC Carswell February 2008 through September 2010.
Q And FMC stands for what?
A I think it's --
Q Is it Federal Medical Center?
A That sounds good, yeah.
Q Okay. And is that the facility that houses -- well, who's housed at the facility?
A All women. They have the max unit there which is the admin unit, the medical unit for all women as well as they have a low and a medium -- or they have a low and a -- I don't know. One of those places where you walk in and out, really low security.
Q And were you a psychiatrist on staff at the FMC Carswell Bureau of Prisons in 2008 to 2010 when Lisa Montgomery came into custody there?
A Yes, ma'am.
Q What was your role at the FMC Carswell during that time frame?
A I was the treating psychiatrist on several different of

Q And the admin unit, is that the unit where Mrs. Montgomery was ultimately assigned to live?
A Yeah. That was the maximum security unit, and that was a separate building in a different part of the campus.
Q And was she assigned to live in that unit because of the nature of her sentence?
A Yes.
Q There's not -- there's Terre Haute, which is the death row for men, but there's really not an equivalent of that for women; is that correct?
A That's correct.
Q Mrs. Montgomery and another woman by the name of Angela Johnson made up federal death row for women?
A Correct.
Q And they both lived in that admin unit?
A Correct.
Q And Ms. Johnson is no longer there. She's out in general population?
A That's my understanding.
Q Did you see Ms. Montgomery in both the M-3 unit and the admin unit?
A Yes, ma'am.
Q As her treating psychiatrist?
A Yes, ma'am.
Q Were you the treating psychiatrist who saw Mrs.

Montgomery when she was received at Carswell?
A Yes.
Q And when she first got to Carswell, did she stay in the M unit for a period of time?
A Yes.
Q And when she left -- why was she there for a period of time?
A First of all, she carried a mental health diagnosis, bipolar disorder. Secondly, she was not doing particularly well psychiatrically. And, thirdly, they didn't really know what they were going to be able to do with her as far as housing, whatever the special corrections requirements were. So she was a transfer from another facility.
Q When you say she wasn't doing well psychiatrically, can you please describe for the Court your personal observations of Mrs. Montgomery that caused you to come to that conclusion?
A She was disheveled, not taking care of her hygiene. She was difficult to get to respond to questions or come to the door and talk.
Q Did you at that time decide that was probably related to her sentence?
A Yes.
Q Over the course of knowing Mrs. Montgomery for two years, did you later come to a different conclusion?
A Yes. That was not her standard presentation. She's

had that presentation a couple of times while I was there. The first time when she came in and later on she had another depressive episode and she looked the same at that time. Most of the time, though, she was happy to talk and chatter away.

Q Was Ms. Montgomery medicated the entire time that you interacted with her at Carswell?

A Yes.

Q And what was she being medicated for?

A She was being medicated for bipolar disorder.

Q And is that a type of mood disorder?

A Yes, ma'am.

Q Does it have psychotic features?

A Yes, ma'am.

Q Did you observe Mrs. Montgomery ever in an acute psychotic state?

A Yes. Particularly the second time she was depressed is when I recognized what was happening the first time. She was in a solo room in the admin unit, wouldn't come to the door, wouldn't talk to me, except she had to because otherwise she would be disciplined correctionally, and was very just dirty, slovenly, which was not her standard, and reported having difficulties with no longer being able to hear the radio properly.

Q When you saw her on the second time, how did she present? What caused you to see her the second episode of

psychosis that you observed? What brought that to your attention?

A The guards called me that there was problems going on, and then when I got to the unit, some of the other inmates on that unit told me I needed to check her.

Q And what did you observe when you checked her?

A That was when I received that symptom that I gave, the symptoms. She was staying back in the room, not getting out of bed, not doing any of her tatting, not able to listen to the radio, one- and two-word sentences were extraordinarily difficult to extract from her.

Q And there was some issue about the radio. Can you explain that?

A We had talked about what some of the symptoms might be for her psychosis; and because she had apparently had a previous experience with an antipsychotic, and the difficulty was that she would not be able to understand what was -- what the words of her favorite songs were when they were playing on her radio, and my interpretation of that was that was a form of psychosis.

Q And had you had a lot of contact with Mrs. Montgomery so you were able to see her in and out of different states?

A Yes, ma'am.

Q Had you developed a relationship of trust with Mrs. Montgomery?

A Yes, ma'am.
Q Because she had been on a previous antipsychotic, did you determine that it was appropriate to try an antipsychotic with Mrs. Montgomery at this time?
A Anyone with a bipolar disorder who is psychotic is deserving of one. She was already on a mood stabilizer, Depakene, and that was not holding her. So in that situation anybody with a mood disorder gets an antipsychotic, who gets psychotic.
Q And what antipsychotic did you choose to use with Mrs. Montgomery?
A I think at first tried some Abilify, which is a newer one of the atypicals, but she did not tolerate it, so eventually returned to Risperidone.
Q Could you spell Risperidone for the court reporter?
A R-i-s-p-e-r-i-d-o-n-e.
Q And what is Risperidone?
A Risperidone has another name, which is Risperdal, which is R-i-s-p-e-r-d-a-l, which is the brand name but working in the VA I now use all generic names. It was the first of the atypical antipsychotics, called atypical because they don't cause as much movement disorder as some of the other older style, Haldol, Prolixin style of old generation antipsychotics.
Q How did Mrs. Montgomery respond to the prescription for the antipsychotic of Risperidone?

A The depression resolved and she went back to being herself.
Q And the psychosis resolved?
A Yes, ma'am.
Q Did she make any representations to you that she could, for example, now listen to the radio and the words on the radio made sense?
A Yes.
MS. HENRY: Just one moment, please, Dr. Kempke.
Thank you very much. That's all I have.
CROSS-EXAMINATION BY MR. VALENTI:
Q Dr. Kempke, my understanding is you were at FMC Carswell from February 2008, did you say?
A Yes.
Q Until 2010? And you saw Ms. Montgomery in April, May, that timeframe of 2008?
A Yes.
MR. VALENTI: That's all I have.
MS. HENRY: That's all, Your Honor.
THE COURT: Thank you, Doctor. You're excused.
(Witness excused.)
MS. HENRY: May it please the Court. Movant calls Dr. Ruth Kuncel.
THE COURT: Good afternoon. Doctor, would you come up over here to the witness stand, please. Thank you.

Q Why was it so significant to you that John was successful in the military?

MR. KETCHMARK: Your Honor, if I might, it's not really an objection. It's more of a -- we did stipulate to her original report and supplement. I would note the original report is 184 pages. The PowerPoint is also -- there's no objection to a stipulation of the PowerPoint. We're not contesting the information that she was able to compile and put together in the biosocialpsych history here. I don't know that we need to go through ad nauseam the PowerPoint because it's all sourced back, and I think they did an excellent job of providing the Court with a roadmap of the information in the 184 pages and then digesting it down with these source attachments here, and so I just think this is cumulative of stuff that we haven't objected to coming in, and I just don't know that we need to do this and go through the 200-page PowerPoint in this fashion.

THE COURT: Ms. Harwell, how are you approaching this?

MS. HARWELL: Your Honor, obviously one of the determinations the Court has to make in light of our ineffective assistance of trial counsel claim is to determine the prejudice not only of trial counsel's failure to investigate and amass the information that's contained in Ms. Vogelsang's report but also in their failure to present it

besides Mr. Kleiner's rape of Lisa?

A Yes.

Q And what was the family secret?

A Judy was engaging, in my opinion, including with Jack regarding the molestation of Lisa, and this form of collusion is well known in studies on child abuse where the mother does nothing to prevent the abuse from happening and in fact goes about it almost as though it's not happening and the child becomes the surrogate for the mother, and in Lisa's case not only sexually but in Judy's other responsibilities as well.

She had servicemen come to the trailer. Her son, Teddy, recalls that there were three or four that would come and all the children would be sent outside and that only Lisa and Judy would remain in the house, and so these were -- this was a plumber, an electrician, and I believe someone who delivered propane gas, but Judy was trading Lisa for those services.

Q Did Lisa disclose this abuse to anyone?

A No, she never did, until recently.

Q Back when she was a child, did she tell her cousin, David Kidwell?

A Her cousin, David Kidwell, who was in law enforcement visited the home and became very concerned about Lisa's demeanor. He felt that she was distressed, and he made the effort to get with her later and she did open up to him and

rather the court proceeding only dealt with Jack Kleiner's rapes of Lisa; is that right?

A Yes.

Q And in your field of social work do you have some concepts that would help us understand why Lisa did not bring all of the sexual trauma to light?

A Well, nondisclosure is a common and typical behavior in abuse cases. She was, I think, now more afraid of her mother and her mother, you know, had this power. She had this omnipotence. Lisa was intimidated by her, and even more so maybe than in other cases you'd see; and because this one is so extreme, Lisa was not about to talk about the things that her mother had done in terms of the family secrets and these servicemen coming to the house.

That is not only common in abuse but going back to strategies for coercive control, again, these are behaviors we've seen among, for example, U.S. soldiers in Korea who cooperated, went along, not because they agreed with their captors but because they had to survive.

Q Was there ramification to Lisa -- did Judy do anything to Lisa to punish her for this disclosure of Jack raping her?

A She cut her hair off and she told her that only good girls had long hair.

Q Were there people around Lisa at that time who were noticing symptoms that were consistent with this kind of

Childhood Experiences Study. The neurobiological research that underpins our understanding of what happens to kids who get abused was very important to me in understanding Ms. Montgomery's functioning, my own clinical knowledge from working for the past 18 years with traumatized people, and, of course, the clinical literature about the diagnoses such as posttraumatic stress, complex trauma; in other words, the literature that talks about what do people who have abuse backgrounds struggle with then.

Q Is it generally accepted in your field to use these sources of science in order to interpret the data you discussed in the slide previously?

A Yes. You need to take that data you've amassed and understand it through a lens of the field, you know, my field being psychology.

Q And is it important for the Court to understand what a normal childhood development, what you called good enough child development is in order to understand your interpretations of Ms. Montgomery?

A I believe there's a few points that are important to understanding about how a child grows that then will be illustrative of what happens when a child's development is derailed by science.

Q So what is the primary task of normal childhood development?

A Well, so when I think about a growing child, one of the things that's very basic, and our field has really demonstrated this, is that child infancy, from being a baby up until growing into adulthood, has this sort of overwhelming task as an organism, a human organism. We call that biopsychosocial regulation.

I can be fairly brief on this. But what the idea of biopsychosocial regulation is that baby from infancy to adult is learning to control and recognize his or her self, his body functions, her senses, her perceptions of the world, her feelings, her interactions, meaning the child is growing to learn how to manage being an organism in the world.

So a quick example would be an infant lying in a crib who experiences discomfort from a wet diaper. That child at four or five months old has no other capacity except one, which is to cry, right? So what that child does is they exert the one regulatory process they can do, vocalization, to express body doesn't feel good. What you hope in normal childhood, again, good enough childhood is that environment will respond to that child. So that baby's going to lie there and a warm face is going to appear that picks the baby up, holds the baby, comforts the baby and says, Oh, we've got to change that diaper, and changes that diaper.

All of that description I just gave is just one little moment, right, in the life of that organism that's

you go sit. You grabbed a toy from your brother. That wasn't nice. Good enough, right? A response with the environment says, This is a limit on you, and that teaches the child. Again, another moment of regulation. I can't grab. I can't hit. When I do these things, the environment will respond. That's why it's an interaction and why each thing the child learns from that environment will shape not only the child's behavior but what we now know, it will shape the child's brain development.

Q So now relevant to Lisa Montgomery's case. What happens to the child when their environment isn't that good enough environment?

A So my clinical evaluation of Ms. Montgomery really yielded a conclusion that her environment was throughout her childhood one of coercion, violence, humiliation, degradation, exploitation. I mean, it was a very horrible childhood. That's going to lead to an adaptation that children make that is often called in our field survival coping, and it's kind of what it sounds like. Survival coping -- if you'd like me to continue?

Q Please.

A It's basically a description that the child is going to adapt. That's the thing about the human organism. We adapt. So when a child's environment is frightening, the child will adapt to managing fear by having physiological fear protection

mechanisms that take place. Let me give an example.

Q What do you mean by that?

A Yes. Sorry. So survival -- I'm going to actually use an example because Ms. Montgomery did one inadvertently, I think, in our interview which is that she was describing at one point being a little girl and having spoken and her mother saying, You don't speak to me, or some way that her mother was angry she had spoken so the mother duct-taped her mouth and made her stand.

Frankly, Ms. Montgomery was describing this very offhandedly, and she talked about what I learned. It's funny. You learn you better not cry too hard because when you cry real hard with duct tape, you can start to get your nose stuffed up, and so I had to learn don't cry too hard because I don't want that nose to get stuffed and I won't be able to breathe.

That's an unbelievably disturbing formulation for a child to have to make, right, about how to not suffocate oneself with duct tape?

In fact, when she said it, the offhanded thing she then said was, Well, I will just daydream during that. That is clinically a very important phrase "daydream."

Q Why so?

A Because Ms. Montgomery was not daydreaming at that point. Daydreaming is the kid sitting in math class and he puts his pencil down and starts looking outside and thinking

they want to go play. What Ms. Montgomery was describing was the beginning of what I'm going to talk about which is of a dissociative style of dealing with stress, fear, and pain, meaning she detached and disconnected.

Again, something we now know about scientifically she detached from the fear, from the overwhelming experience. So what she calls daydreams is, in my opinion, the beginning of her learning to dissociate.

Q And how does this survival coping affect the brain? Does it cause brain changes?

A Yes. This has been really an exploding part of our field for the last 30 years which is that the things that children do under traumatic stress have been shown now to be adaptations that make lasting, permanent changes in the brain.

There's three -- I'm really not going to do a big deep dig on the science here but if I could just briefly sort of frame. There's three major areas the research has looked at what we call the neurochemical aspect of brain development. That's the brain messengers that send signals to us. The neuroendocrine system, which is the hormonal system which regulates much of the bodily functioning, including response to stress; and the neuroanatomical, meaning simply that brain structure, that actual mass that is the brain.

Again, I'm not going to summarize them all here, but I did provide a very lengthy bibliography. There's extensive

literature on what those changes have been shown to be in maltreated children.

Q Let me ask you for just a moment about that. Was this information, this science available to clinicians such as yourself in 2007 when Mrs. Montgomery's case was tried?

A It was.

Q Can you just explain, again, briefly. I know you prepared a slide about the neurotransmitters and the like. Can you briefly summarize --

A Sure.

Q -- these brain changes?

A Again, I'll do it by the categories. So neurotransmitters are the brain chemicals that connect the synapses of our neurons, those little spaces between the nerves and our brain. The reason it's interesting -- I said trillion before. We believe that children have trillions of synapse connectivity moments, meaning moments when things are firing as they are developing, which is kind of an incredible idea, and those -- what we've shown is that the chemicals that go across the synapses that create the connectivity between our nerves and our brains have shown alteration, if you study stressed, traumatized kids, and the alterations are that they have overactivation of some.

It depends -- now, I'm not going to break down all these neurotransmitters. There's overactivation of some of

them, there's underactivation of others. You see impairments, frankly, in the quantity of the chemicals that are in the child's brain and how they're interacting.

Sorry. Do you want me to just say about the neuroendocrine system?

Q Yes. Sorry. You're the scientist. I'm not. So can you tell us about the neuroendocrine system?

A I can do this quickly. The neuroendocrine system is our hormonal system that manages stress, the part of our body that handles -- sorry -- the system in our body that handles digestion, alertness, appetite, and it is a deeply sensitive system because it has to handle all of the ways we are as a person.

When children are put under severe stress and strain and fear, their neuroendocrine system has now been shown scientifically to have alteration. I'll give one quick example. There's something called cortisol that gets released in the body after you've been through something very, very stressful. So if I were hit by a car and then they took me to the hospital and I was awake, very frightened and then afterwards they quickly took a sample of my saliva, what they'd probably find is that the cortisol in my saliva would be at a very high rate, and that's because that cortisol is what goes kind of pouring into the human body to calm it down after a trauma; and so what we see in traumatized children is they have

excessive and under -- they have too much and too little cortisol, depending on -- it's a deeper analysis than I'll do here, but the point is their stress response system is not activating itself in a normal way. It's activating itself in an overly stressed way. That's an example of a neuroendocrine.

Q And that can actually affect the changes in the brain as a child?

A Absolutely, yes. The cortisol particularly has been shown -- there is a direct link between the function -- the structure of the brain, which is the next part of the slide, which is something called the corpus callosum -- and I have one thing for a moment, if I could, because it does relate to findings of Ms. Montgomery.

Corpus callosum is an anatomical part of the brain. It's literally down the middle and it connects the right and left hemispheres. What we have found recently in robust studies is that too much of that cortisol stress response shrinks that corpus callosum, which is kind of incredible because what we're now seeing is that abused children as they grow have a smaller corpus callosum which means they have less connectivity between left and right parts of their brain, and that connectivity is everything for people. That's how we put things into words because our left hemisphere is language broadly, connects with our right, which has to do with our perceptions.

So to have that proof that abused children have less connectivity, I'm thinking now about Ms. Montgomery's IQ test that shows this very large discrepancy between her verbal capacity and performance capacity. That is a really important finding now about what happens to children under stress.

Q And does it matter at what point in the child's development that they experience this chronic severe stress?

A Yeah. I mean, one of the things that's really amazing about the brain also is how much of it develops what we call postnatally. You're not born with a functioning brain that we now have as adults. It develops over the course of the child's life.

There are critical periods in children's lives where there's real explosions of brain development. One of them at adolescence. Another one tends to be in that preschool area, sort of three to -- sorry -- two to four, and one of those things that sometimes gets used in my field is what fires together wires together.

The idea there is if a child's brain is required to be in a certain state, let's say, a state of fear and threat detection, I have to protect myself, I'm under threat, the parts of the brain that handle fear and threat detection are firing, right? That's trillions of connections. And then they become wired. They become permanently connected. So that child's brain is now what we think of as a survival brain.

It's a brain ready for fear. It's ready for threat. It's not a brain really ready to do sort of the normal things that kids have to do. That's how it becomes problematic.

There's also functional parts of the brain, the frontal lobe up here and the limbic system, which handles our emotions that are not even formed until really late adolescence -- not completely formed until late adolescence.

Q So how is the frontal lobe impacted -- let me ask you this question: When Mrs. Montgomery -- there's been testimony about the fact that really she experienced physical trauma from birth on and it was constant throughout childhood, and then the sexual trauma began probably around eight or nine and continued on and continued to get worse and worse and worse. So when you're experiencing this physical, emotional, sexual trauma throughout the course of her development from birth to --

A Yes.

Q -- 18, is it -- do we know something about the way the frontal lobe and the limbic system would be affected?

A Well, what's sad about it, frankly, in this case is that the critical periods of development for, let's say, the limbic system. That limbic system, by the way, again is the emotional responses of the child. One of the critical developmental periods of the limbic development is early childhood.

So what we found is that if children are abused,

maltreated, frightened during their younger years, sometimes they're going to demonstrate later what we call affective problems, problems with their feelings, handling them, what we call emotional dysregulation. So we've got Mrs. Montgomery certainly experienced in early childhood -- while that limbic system was formulating itself and growing, she experienced great abuse, fear, abandonment, neglect.

I was going to say the frontal lobe gets shaped much more in those and really solidified in the adolescence and later adolescence. What we find with teenagers who are abused is that they suffer more of those cognitive impairments that come from frontal lobe damage. So trouble planning, trouble thinking things through, trouble with their reasoning capacity and handling emotion and reasoning together, you know. Making a good decision, essentially.

So then we've got Ms. Montgomery abused severely as an adolescent, and we see in Mrs. Montgomery's clinical condition the detrimental effect of that, which is terrible, terrible functioning in planning, impulse control, and reasoning.

So sadly you see the critical periods for her because the abuse took place across her childhood, in her adolescence many of the critical periods where times she was under severe traumatic stress and, therefore, her functioning became impaired.

adverse childhood events, again, we're not even talking about looking at the length of these events in the child's life; but if you are talking at that level of adversity, you're going to be looking at worse and worse functioning afterwards.

And so with Ms. Montgomery, for instance, if we just do a broad-base look at her as a subject of the ACE evaluation, you see that she has nine out of ten ACE events in her childhood. That is an astonishing load of adversity.

Q And just to briefly go through Mrs. Montgomery's clinical condition, can you describe for the Court what your findings were with respect to her clinical condition?

A Yes. So I think to do that it would be helpful if I could talk about posttraumatic stress disorder for a few minutes and describe how that happens to people.

Q First of all, let me ask you, did you give Mrs. Montgomery -- did you believe that posttraumatic stress disorder is part of her overall --

A Yes. Mrs. Montgomery has posttraumatic stress disorder. In fact, she has what I would call complex posttraumatic stress disorder which has to do with pervasive, long-standing traumatic events as opposed to sort of one or two exposures.

Q So we're going to break that down. In order to understand complex trauma and complex PTSD, we first need to understand PTSD. So could you explain PTSD to the Court?

because it helps the child either get away, fight the person off, or what we later see is shut down and freeze. So that fear response is useful.

However, after the trauma is over, it's not so useful to have the fear response continuing to fire, and people who have posttraumatic stress have that. The way we understand it is that when the trauma occurs, the brain is laying down a memory of what happened, okay? As that brain is laying down that memory, let's say, again, the car is coming and I'm going to remember this moment of this car coming towards me. As that's happening, I'm in a state of fear, and the dysfunction of PTSD is that we understand now that the part of the brain that encodes memory is the hippocampus, the larger system than that but the hippocampus is the main structure. If laying down that memory as the amygdala, the part of the brain we talked about the limbic system, is sending fear.

So later the memory of the trauma activates the fear, and so the terrible thing about posttraumatic stress is that for people who have been traumatized, remembering is actually being afraid. In other words, when they remember, they feel fear in their body, and my patients and many people I've worked with describe this. It's not, Oh, it's a bad memory, it makes me upset. That's, of course, true. It's that if you make me remember, I am going to feel those physiological feelings of fear again.

lifelong or chronic condition of fear, trauma, and being overwhelmed; and the sort of model of that is called complex posttraumatic stress, and that -- we've learned this through war survivors, kids growing up in war zones, kidnap survivors, children who have been chronically abused. These are the populations who have a posttraumatic condition, but we look at it as having more impairments, more pervasive problems in the functioning, and it's sort of best understood, I think, as a captivity condition, meaning the person's trauma came out of a situation they could not get out of, sometimes called learned helplessness, meaning -- excuse me -- the captivity sometimes is described as leading to learned helplessness which is a condition in which the person realizes there is nothing they can do to escape. I've seen that in several kidnap survivors.

Q Let's discuss this concept of learned helplessness a little bit because you're aware that at the trial in this case, as we suggested -- as we talked about yesterday, there was a question as to whether or not Mrs. Montgomery's complex PTSD was not diagnosed, and there was a question about whether or not Ms. Montgomery's PTSD was simply from the crime itself, and there were also many questions raised as to whether or not Mrs. Montgomery was a, quote, willing participant in the sexual trauma that they knew about at least at the time of the trial. Can you describe this concept of learned helplessness, because I think it's very important to understand that?

complex posttraumatic stress?

A Yes. So if we think back again to those risk factors we talked about with the ACE Study and there's been other -- ACE is not the only study to look at risk factors. In fact, the Department of Justice looked at risk factors in children and says that if kids have these problems, they're going to go on to have trouble with delinquent and -- delinquent behavior.

The risk factors I'm identifying here you see on the slide are basic things that Lisa experienced in her childhood; and, frankly, they are over a long period of time that I believe are critical to understanding her very poor outcome as an adult.

Q So it's important for us to talk about all of these risk factors. We talked a lot about sexual abuse. That's been a lot of the focus over the last week and a day, but the sexual abuse is there but there's also other types of abuse; is that correct?

A Yes. So Ms. Montgomery's --

Q Let's start first with the sexual abuse and move through that quickly, then we'll get into the risk factors.

A I mean, so just broadly there is just such extensive sexual abuse in this woman's childhood that is well documented, well reported, including reported before the events of the crime and documented by experts and professionals, not simply family members. There is her -- actually, I realize I do not

have up there that she was sexually assaulted by a relative, Kenny, I believe his name is.

Q Her cousin, Kenny Alexander, when she was a small child?

A Yes. But then really the first two points --

Q The gang rapes and the trafficking, you're aware that that's something that the jury didn't know about; is that fair to say?

A Did not know about?

Q Right.

A Correct.

Q That was new information that you learned from your interview of David Kidwell and your interview of Lisa Montgomery?

A Correct. So I was just pausing because Diane's rape I have there with Lisa Montgomery present predates the other events because Lisa was herself a small child at that point. I believe Ms. Mattingly estimates Lisa was about three or four when she was lying in bed while Diane, seven or eight, was being raped by an adult male. So we're going to start with that -- a starting point of sexual abuse because for a four-year-old child to be lying in that situation would be unbelievably frightening and would be a condition of sexual abuse.

Sorry. To then return to your question. Lisa

Montgomery's experience of being groomed by Jack Kleiner starting at approximately age 11, if not earlier, with fondling, nudity, physical punishment being coupled with the nudity, being forced to bend over a bathtub with her bare bottom exposed and growing into at age 13 an experience of frank rape by him is just an astonishing amount of abuse for a child to absorb. It is very, very severe.

When you then add that what has emerged is that she also was trafficked by her mother, other caretaker, who is supposed to protect, traffics to other adult men who multiply raped her, beat her, and urinated on her, it is almost incomprehensible the kind of stress this child's body and mind suffered; and, frankly, her disordered behavior shows the cost in terms of how severely disturbed she is.

Q So we've talked about the sexual abuse. What about the physical abuse?

A Again, these are well documented, multiple witnesses talking about just an extensive and very just sadistic sort of tone in this child's home by her mother and stepfather in terms of being, you know, put in a shower when she had wet her bed, in a cold shower, just cruel physical treatment. Being whipped with multiple objects; belts, cords, wire hangers.

A story told by someone else of Judy hitting Lisa with a hairbrush over the head, having a broom broken over her back by her adult stepfather and also being hit and beaten

during the rape to the point where she said she would have bruises sometimes on her legs after the rape by these men. When you talk about dose, we're talking about just an enormous dose of physical violence in this child.

Q And did Mrs. Montgomery tell you that sometimes she would have to wear long dresses in order to cover up the beatings on her legs?

A Yes, she did.

Q And told you that the beatings were allowed?

A Yes.

Q During the gang rapes?

A That's correct.

Q Did Mrs. Montgomery also tell you that some of these men would leave her money because they knew that Judy wasn't sharing all the proceeds with her?

A Yes. She talked about a man who would open the drawer of her dresser and sort of slip this money in; which, again, if you try to think about a child developing in the world and conceiving of what people are and what adults are, it's so perverse to think of a child having just been raped by an adult male as he slips money into her dresser and the mother is in the other room.

Q Let's talk about the next factor, emotional abuse, and I know there is a lot of emotional abuse when we get back to talk about that dose of stress. What were some of the

instances of emotional abuse that you were able to document in the records?

A Again, there is a staggering amount of abuse enacted on Lisa Montgomery as a child and adolescent that I would call emotional. By emotional abuse, that is cruelty towards her, verbal, psychological manipulation, things designed to really make her feel terrible.

You know, there is just a tone across this family of disparagement and sort of vicious language being used towards children. There is -- the experience of Ms. Mattingly as a child being told, You are going to be removed from the home because you're bad, you're not ours. Again, this is now -- that's an emotionally abusive situation for Ms. Montgomery as well because she's a little child watching her big sister, beloved, being threatened with abandonment. This is so frightening for children. Watching Diane Mattingly being put on the porch naked. This is emotionally abusive to Lisa Montgomery, of course, as well as to Ms. Mattingly.

Q What about Jack's threats?

A Well, you know, Mr. Kleiner by all accounts was just an unbelievably frightening man, and he threatened Lisa that he would rape her sister if she told. So Lisa now has the double bind, I have to submit to the rape because if I don't, my sister gets it. He also threatened, though, to kill the family if she told. This was a very important point to me because it

led to a real feeling of, I believe, learned helplessness that I talked about earlier in Lisa. He's saying, I will kill your family.

If you want to sort of think about part of my questioning was evaluating her, what was the believability of that threat? What I found in the records was that Judy Kleiner herself in her divorce proceeding says, Part of why I didn't want to leave or kick him out, rather, was I believed he was going to kill us. So there you've got a grown woman saying this man is capable of hurting, slash, killing his family. So when a little child, 11, 12, 13, 14 feels it, that to me is quite credible.

Other abuse --

Q And what abuse, emotional abuse did you see, for example, with Judy with respect to Lisa?

A Well, again, I believe Mrs. Kleiner was very mentally ill because her -- the things she was capable of doing to her children are really astonishing in their cruelty. Cutting Lisa's hair as a symbol of you're bad and dirty. That's a very disturbing concept for a child that you are physically now going to be changed by me into less attractive -- whatever the meaning of the short hair is -- because you're bad and dirty. That's a very, very disturbing message for a child.

It really leads to the most powerful emotional abuse that I believe happened to Lisa Montgomery by her mother, which

was that after this extensive years of sexual abuse was discovered, Mrs. Kleiner blamed Lisa for the abuse, said that she had done it, she had stolen her husband, said she had broken up the family. She said she had made it so we don't have money now. It's very difficult to try to capture how damaging that message is to a child who suffered sexual abuse.

When kids suffer sexual abuse, one of the biggest predictors of improvement in their functioning, helping them is does the system respond in a way to protect them, to prosecute the perpetrator and do they get loving family support from those who care for them.

Q And what you have just described, would that have been relevant to rebut the prosecution's argument at trial that hundreds of thousands of children are sexually abused but their outcomes are fine?

A Oh, absolutely, because the variables that matter are all in the details, right? What was the extent of the abuse and what happened after? What are those protective factors? I can talk about that later, if you like. But this idea of Mrs. Kleiner saying to Lisa, This is your fault, is really just a staggering kind of damage to do to a child.

Q And the other instances that you have here on this slide, such as allowing Jack back into the home, sending Lisa away, and publicly humiliating Lisa, are those all examples of Mrs. Kleiner doing what to Lisa?